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Office of Administrative Law Judges
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Issue Date: 26 February 2007

In the Matter of:

H.L.,
Claimant

Case No.: 2004-BLA-00102

v.

CAROL COAL CORPORATION,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Ron Carson
Stone Mountain Health Services
Saint Charles, Virginia
For the Claimant

Russell Vern Presley, Esq.
Street Law Firm
Grundy, Va.
For the Employer

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER DENYING REQUEST FOR MODIFICATION

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq. The Act and implementing regulations, 20 CFR Parts 410, 718, 725 and 727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2006). In this case, the Claimant alleges that he is totally disabled by pneumoconiosis.

I conducted a hearing on this claim on October 26, 2004, in Abingdon, Virginia. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2006). The Director, OWCP, was not represented at the hearing. The Claimant was the only witness. Transcript ("Tr.") at 13-20. Director's Exhibits ("DX") 1-73, Claimant's Exhibits ("CX") 1-4 and Employer's Exhibits ("EX") 1-10 were admitted into evidence without objection. Tr. at 6, 7 and 9. The record was held open after the hearing to allow the parties to submit additional evidence, and closing arguments, which were optional. I hereby admit the following additional exhibits which have been submitted timely by the parties: CX 5, Dr. Alexander's re-reading of the x-ray taken August 4, 2004; and EX 11, the deposition of Dr. Hippensteel. No closing arguments were filed. The record is now closed.

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits admitted into evidence, the testimony at hearing and the arguments of the parties.

PROCEDURAL HISTORY

The Claimant filed his initial claim on December 11, 1978. DX 1. The claim was denied by the District Director of the Office of Workers' Compensation Programs ("OWCP") on June 11, 1980, on the grounds that the evidence did not show that the Claimant was totally disabled due to pneumoconiosis. According to the District Director, the Claimant was still working in the mines. The Claimant did not appeal that determination.

More than one year later, the Claimant filed a duplicate claim. DX 2. The duplicate claim was denied by Administrative Law Judge ("ALJ") Paul H. Teitler on August 6, 1992. Judge Teitler found that the Claimant suffered from pneumoconiosis but was not totally disabled due to the disease. The Claimant appealed this decision to the Benefits Review Board (the "Board"), and on February 25, 1994, the Board affirmed Judge Teitler's decision and order. The Claimant appealed the Board's decision to the Fourth Circuit Court of Appeals, and on January 6, 1995, the Court affirmed the decision of the Board.

On March 17, 1997, the Claimant filed the instant claim. DX 3. The District Director, OWCP, initially denied the claim on June 9, 1997, and again on March 17, 1998. DX 20; DX 37. The Claimant appealed this decision on March 24, 1998. DX 39. The claim was denied on September 1, 1999 by Administrative Law Judge Roketenetz. DX 47. Administrative Judge Roketenetz held that the Claimant failed to establish that he was totally disabled due to pneumoconiosis.

By letter dated July 27, 2000, the Claimant filed a Request for Modification. DX 48. On September 13, 2000, the District Director denied this request for modification. DX 50. On August 21, 2001, the Claimant again requested modification. DX 52. The District Director denied this request on September 25, 2001. DX 55. On August 23, 2002, the Claimant filed a third request for modification, which the District Director denied on October 15, 2002. DX 55; DX 62. The following year, on October 3, 2003, the Claimant filed a fourth request for modification, which was denied by the District Director on December 31, 2003. DX 63; DX 66.

On January 26, 2004, the Claimant requested a formal hearing, and this request for modification was referred to the Office of Administrative Law Judges on April 6, 2004. DX 67; DX 71.

APPLICABLE STANDARDS

This claim relates to a request for modification of an adverse decision on a "duplicate" claim filed on March 17, 1997. Because the claim at issue was filed after March 31, 1980, the regulations at 20 CFR Part 718 apply. 20 CFR § 718.2 (2006). Parts 718 (standards for award of benefits) and 725 (procedures) of the regulations underwent extensive revisions effective January 19, 2001. 65 Fed. Reg. 79920 et seq. (2000). The Department of Labor has taken the position that as a general rule, the revisions to Part 718 should apply to pending cases because they do not announce new rules, but rather clarify or codify existing policy. See 65 Fed. Reg. at 79949-79950, 79955-79956 (2000). Changes in the standards for administration of clinical tests and examinations, however, would not apply to medical evidence developed before January 19, 2001. 20 CFR § 718.101(b) (2006). The new rules specifically provide that some revisions to Part 725 apply to pending cases, while others (including revisions to the rules regarding duplicate claims and modification) do not; for a list of the revised sections which do not apply to pending cases, see 20 CFR § 725.2(c) (2006). The U.S. District Court for the District of Columbia upheld the validity of the new regulations in *National Mining Association v. Chao*, 160 F.Supp.2d 47 (D.D.C. 2001). However, the Court of Appeals affirmed in part, reversed in part, and remanded the case. *National Mining Association v. Department of Labor*, 292 F.3d 849 (D.C. Cir. 2002) (Upholding most of the revised rules, finding some could be applied to pending cases, while others should be applied only prospectively, and holding that one rule empowering cost shifting from a claimant to an employer exceeded the authority of the Department of Labor). On December 15, 2003, the Department of Labor promulgated revisions to 20 CFR §§ 718.2, 725.2 and 725.459 implementing the Circuit Court's opinion. 68 Fed. Reg. 69930 et seq. (2003). Accordingly, I will apply only the sections of the newly revised version of Parts 718 and 725 that the court did not find impermissibly retroactive. In this Decision and Order, the "old" rules applicable to this case will be cited to the 2000 edition of the Code of Federal Regulations; the "new" rules will be cited to the 2006 edition.

Pursuant to 20 CFR § 725.310 (2000), in order to establish that he is entitled to benefits in connection with his current claim, the Claimant must demonstrate that there has been a change in conditions or a mistake in a determination of fact such that he meets the requirements for entitlement to benefits under 20 CFR Part 718. In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203 and 718.204 (2006). I must consider all of the evidence pertaining to his duplicate claim to determine whether there has been a change in conditions or a mistake of fact by ALJ Roketenetz; new evidence is not required for me to reach a determination that there has been a mistake of fact. *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254 (1971); *Jessee v. Director, OWCP*, 5 F.3d 723 (4th Cir. 1993).

Because the underlying claim is a duplicate claim, in order to be entitled to benefits, the Claimant must also establish a material change in conditions since his previous claim was denied. 20 CFR § 725.309(c) (2000). I must consider the new evidence and determine whether the Claimant has proved at least one of the elements of entitlement previously decided against

him. If so, then I must consider whether all of the evidence establishes that he is entitled to benefits. *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358, 1362-1363 (4th Cir. 1996).

ISSUES

The issues contested by the Employer, or by the Employer and the Director are:

1. Whether the claim was timely filed.

2. Whether the Claimant has pneumoconiosis.

3. Whether he is totally disabled.

4. Whether his disability is due to pneumoconiosis.

5. Whether the named Employer is the Responsible Operator.

6. Whether the evidence establishes a change in conditions or a mistake in a determination of fact in the prior denials of the current claim pursuant to 20 CFR § 725.310 (2000).

7. Whether the evidence establishes a material change in conditions since denial of the previous claim pursuant to 20 CFR § 725.309 (2000).

DX 71; Tr. 5-6.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

The Claimant testified that he was 81 years old at time of the hearing. Tr. 13. The Claimant has a tenth-grade education. DX 2.

He worked for Carol Coal Company from 1975 to 1987. He did not work for any other coal company after that. Tr. 16. The District Director found that the Claimant had 39 years of coal mine employment, and the Employer did not contest that issue. DX 71; Tr. 5-6, 10. His last coal mine employment was in Virginia. DX 11. Therefore this claim is governed by the law of the Fourth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc).

The Claimant agreed that he smoked one pack of cigarettes per day for 38 years. He said he quit smoking in 1987, when he had heart surgery. Tr. 17. He said his wife does not smoke, and his did not know why he had elevated carboxyhemoglobin at a medical examination in August 2004. Tr. 17-18.

Timeliness

Under 20 CFR § 725.308(a), a claim of a living miner is timely filed if it is filed "within three years after a medical determination of total disability due to pneumoconiosis" has been

communicated to the miner. 20 CFR § 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. The purpose of the regulation allowing the filing of duplicate claims, 20 CFR § 725.309 (2000), is "to provide relief from the ordinary principles of finality and res judicata to miners whose physical condition deteriorates." *Lukman v. Director, OWCP*, 896 F.2d 1248, 1253 (10th Cir. 1990). The Benefits Review Board has held that there is no statute of limitations or time limit for filing a duplicate claim. *Andryka v. Rochester Pittsburgh Coal Co*., 14 B.L.R. 1-34 (1990). This view is not universally accepted by the courts. *Compare Wyoming Fuel Co. v. Director, OWCP*, 90 F.3d 1502, 1507 (10th Cir. 1996) ("… a final finding by an … adjudicator that the claimant is not totally disabled due to pneumoconiosis repudiates any earlier medical determination to the contrary and renders prior medical advice to the contrary ineffective to trigger the running of the statute of limitations."); *Westmoreland Coal Co. v. Amick*, 2004 WL 2791653, *3 (4th Cir. 2004) (unpub.) (rejecting the Board's view, but agreeing with *Wyoming Fuel*); *Tennessee Consolidated Coal Co. v. Kirk*, 264 F.3d 602, 608 (6th Cir. 2001) ("The three-year limitations clock begins to tick *the first time* that a miner is told by a physician that he is totally disabled by pneumoconiosis. This clock is not stopped by the resolution of the miner's claim or claims, and … may only be turned back if the miner returns to the mines after a denial of benefits.") (Emphasis in original). The Claimant's previous claim was denied by the Fourth Circuit Court of Appeals on January 6, 1995, and his current claim was filed less than three years later. Applying the *Wyoming Fuel* standard to this case, it must be considered timely, as any medical testimony in the prior claim that the Claimant was totally disabled by pneumoconiosis was repudiated. Moreover, the Employer has offered no evidence or argument on this issue. I find that the presumption of timeliness has not been rebutted, and the claim is timely.

Responsible Operator

The Claimant testified that he worked at Carol Coal Company from 1975 until 1987, and that he did not work at any coal mine thereafter. He left the mines due to his physical and medical condition. DX 3. The Director found that the Claimant worked for Carol Coal from 1975 to 1987, verified by Social Security records. DX 11. The evidence supports the conclusion that the Claimant was a miner last employed by Carol Coal, a mine operator, for 13 years. There is no evidence that Carol Coal is unable to assume liability in the event the Claimant is found to be eligible for benefits. I find that Carol Coal is the Responsible Operator in this case pursuant to 20 CFR §§ 725.491, 492 and 493 (2000).

Material Change in Conditions

In a duplicate claim, the threshold issue is whether there has been a material change in conditions since the previous claim was denied. The first determination must be whether the Claimant has established with new evidence that he suffers from a totally disabling pulmonary or respiratory impairment. Absent a finding that he suffers from such impairment, none of the elements previously decided against him can be established, and his claim must fail, because a living miner cannot be entitled to black lung benefits unless he is totally disabled based on pulmonary or respiratory impairments. Nonrespiratory and nonpulmonary impairments are irrelevant to establishing total disability for the purpose of entitlement to black lung benefits. 20 CFR § 718.204(a) (2006); *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (4th Cir. 1994); *Beatty v. Danri Corp*., 16 B.L.R. 1-11, 1-15 (1991), *aff'd*. 49 F.3d 993 (3d Cir. 1995).

In his decision on the previous claim, Judge Teitler found that the Claimant had pneumoconiosis, but that he was not totally disabled by it. As will be discussed in detail below, the medical evidence filed in connection with his current claim confirms that he has pneumoconiosis, but does not establish that the Claimant is totally disabled by a pulmonary or respiratory impairment. Thus I find that he has not established that a material change in conditions has occurred. It follows that I do not need to address the evidence in the record from his previous claims in explaining my decision that he is not entitled to benefits.

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in connection with the current claim.

The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2000). Any such readings are therefore included in the "negative" column. X-ray interpretations which make no reference to pneumoconiosis, positive or negative, given in connection with medical treatment or review of an x-ray film solely to determine its quality, are listed in the "silent" column.

Physicians' qualifications appear after their names. Qualifications of physicians who classified opacities observed on x-ray have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the lists of readers issued by the National Institute of Occupational Safety and Health (NIOSH), and/or the registry of physicians' specialties maintained by the American Board of Medical Specialties.[1] If no qualifications are noted for any of the following physicians, it means that either they have no special qualifications for reading x-rays, or I have been unable to ascertain their qualifications from the record, the NIOSH lists, or the Board of Medical Specialties. Qualifications of physicians are abbreviated as follows: A= NIOSH certified A reader; B= NIOSH certified B reader; BCR= board-certified in radiology. Readers who are board-certified radiologists and/or

[1]NIOSH is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination. Historical information about physician qualifications appears on the U.S. Department of Health and Human Services, Comprehensive List of NIOSH Approved A and B Readers, August 29, 2005, found at http://www.oalj.dol.gov/PUBLIC/BLACK_LUNG/REFERENCES/REFERENCE_WORKS/BREAD3_08_05.HTM. Current information about physician qualifications appears on the CDC/NIOSH, NIOSH Certified B Readers List found at http://www.cdc.gov/niosh/topics/chestradiography/breader-list.html. Information about physician board certifications appears on the web-site of the American Board of Medical Specialties, found at http://www.abms.org.

B readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be radiologists.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
06/25/91		DX 44, DX 45 Dahhan B	
11/17/92		DX34 Wheeler BCR/B DX 34 Scott BCR/B DX 35 Templeton BCR/B DX 44, DX 45 Dahhan B	
04/23/97	DX 18 Forehand B 1/2 DX 19 Cole BCR/B 1/2	DX 32 Wheeler BCR/B DX 32 Scott BCR/B 0/1	
08/04/97	DX 33 Robinette B 2/2	DX 34 Wheeler BCR/B DX 34 Scott BCR/B DX 35 Templeton BCR/B DX 44, DX 45 Dahhan B	
09/17/97		DX 38, DX 44, DX 45 Dahhan B	
06/14/00	DX 53 Navani BCR/B 1/0		DX 48; DX 52 Kubota Diffuse mild interstitial process
05/07/01	DX 52 Alexander BCR/B 2/2		
01/03/02	DX 61 Navani BCR/B 1/2 DX 59, DX 63 Ahmed BCR/B 2/1	EX 1 Wheeler BCR/B EX 3 Scott BCR/B	

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
04/14/03	DX 63 Alexander BCR/B 2/3 DX 65 Navani BCR/B 1/1	EX 1 Wheeler BCR/B EX 3 Scott BCR/B EX 7 Wiot BCR/B	
08/04/04	EX 5 Hippensteel B 2/1 EX 8 Wiot BCR/B 1/1 CX 5 Alexander BCR/B 2/1 EX 9 Dahhan B 1/2		

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. Tests most often relied upon to establish disability in black lung claims measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

The following chart summarizes the results of the pulmonary function studies available in connection with the current claim. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2006).

Ex. No. Date Physician	Age Height[2]	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 17 04/23/97 Forehand	73 68”	2.09	3.09	68%	76	No	Mildly obstructive ventilatory pattern
DX 38 09/17/97 Hippensteel	74 67”	2.11 2.21	2.91 2.98	73% 74%	87 85	No No	Spirometry shows values in lower normal range pre and post bronchodilators in spite of suboptimal peak effort. MVV invalid. Lung volumes are in normal range. Diffusion is normal.
DX 48 05/16/00 Bickley[3]	76 71”	1.80	2.46	73%	63	Yes	Moderate restriction DX 49 Invalidated by Dr. Michos
DX 52 06/07/01 Bickley	77 71”	2.21	3.11	71%	46.0	No	Mild restriction
DX 52 09/22/00 Veterans’ Medical Center	77 68”	1.77 1.86	2.60 2.65	68% 70%	63	Yes No	No obstruction. Mild restriction
DX 55; DX 57 04/23/02 Narayanan	78 71”	2.06	3.01	68%	45.2	No	Normal DX 57 Validated by Dr. Michos, except for MVV

[2] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance in the recorded height of the miner from 68” to 71”, I have taken the mid-point (69.5”) in determining whether the studies qualify to show disability under the regulations.

[3] Dr. Bickley is board certified in family medicine. DX 48.

Ex. No. Date Physician	Age Height^2	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 59; DX 60 08/13/02 Smiddy	79 71"	2.00	3.08	65%		No	Obstructive ventilatory defect DX 60 Invalidated by Dr. Michos – only one trial reported
EX 5 08/04/04 Hippensteel	80 68"	1.87	2.60	72%	40	No	Unable to complete PFT. No obstruction or restriction. MVV underestimates function.

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (PO_2) and the percentage of carbon dioxide (PCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled.

The following chart summarizes the arterial blood gas studies available in connection with the current claim. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b) (2006).

Exhibit Number	Date	Physician	PCO_2 at rest/ exercise	PO_2 at rest/ exercise	Qualify?	Physician Impression
DX 16	04/23/97	Forehand	34 32	72 70	No No	Normal
DX 38	09/17/97	Hippensteel	36.9	84	No	Normal gas exchange at rest. Carboxyhemoglobin level is normal.
CX 1	05/02/01	Mathai	32.9	83	No	

Exhibit Number	Date	Physician	PCO_2 at rest/ exercise	PO_2 at rest/ exercise	Qualify?	Physician Impression
EX 5	08/04/04	Hippensteel	34.1	87.4	No	Normal gas exchange at rest. Carboxyhemoglobin level is significantly elevated.

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv) (2006). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2006). The record contains the following medical opinions relating to the request for modification.

Treatment Records

The Claimant underwent coronary artery bypass grafting on January 30, 1987. DX 14. According to the operative notes,

> … Attempts to take the pleura down from the left chest wall were to no avail. The severe pulmonary disease that the patient has accumulated over years in the mine was evident and marked anthracotic changes of the lungs which had affected the pleura. There were multiple small ant[h]racotic nodes throughout the chest wall.

The record contains treatment records from Mountain Home Veterans Hospital from June 14, to August 22, 2001. CX 1, DX 52. X-ray and pulmonary function results appear on the tables above. After an abnormal stress test, the Claimant underwent cardiac catheterization on April 4, 2001, which resulted in findings of mild ischemia with preserved left ventricle function, and a recommendation of medical management. In follow-up, the Claimant reported chest pain with exertion, usually relieved with nitroglycerin. The clinical history reported that the Claimant had a known history of coronary artery disease, status post coronary artery bypass grafting in 1987. The Claimant also reported that he had been diagnosed with chronic obstructive pulmonary disease (COPD) years before. On May 2, 2001, the Claimant was seen by Dr. Mathai in consultation for a pre-operative examination after the Claimant's wife reported that the Claimant had increasing shortness of breath with his activities of daily living. He was unable walk a full flight of stairs without stopping, and had to sit up at night in a chair to keep from

smothering. Dr. Mathai noted the Claimant worked in the coal mines for 20 years and smoked for 40 years at one pack per day. He took social, family and medical histories, and performed pulmonary function studies, arterial blood gas studies and physical examination. Listed prescriptions included one for Albuterol, two puffs, four times daily. Lungs were clear except for minimal crackles in the right base. Laboratory results were within normal limits except for the arterial blood gas study. Pulmonary function tests showed an FEV_1/ FVC ratio of greater than 100%. Dr. Mathai did not list any diagnoses.

The Claimant was seen by Dr. Smiddy for a pulmonary consultation on January 3, 2002.[4] DX 55. Dr. Smiddy is board certified in Internal Medicine. CX 3, DX 59, DX 55. He took occupational, social, family and medical histories, and conducted a physical examination and chest x-ray. He reported that the Claimant worked in the mines for 39 years, and was a former smoker who quit at age 60. The chest examination revealed reduced breath sounds. Dr. Smiddy read the x-ray as showing pneumoconiosis. Dr. Smiddy diagnosed chronic bronchitis, coal worker's pneumoconiosis, obstructive lung disease, and coronary artery disease, and prescribed several medications. He recommended that a B reader x-ray be obtained, and arranged for follow-up.

The Claimant submitted a progress note from Dr. Smiddy dated September 15, 2003. CX 3. Dr. Smiddy noted a history of chronic shortness of breath, coal mining, coal dust exposure and exercise limitation, with a prior history of heart attack, asthma and emphysema. The note recorded that the Claimant had been seen previously on August 13, 2002, when Dr. Smiddy gave him a statement that he was disabled by coal workers' pneumoconiosis; there is no progress note from that visit in the record. Chest examination on September 15 revealed diminished breath sounds. The Claimant's pulmonary function test was in a "similar range" with an FVC of 2.94, and an FEV1 of 1.94 on a bronchodilator. Dr. Smiddy diagnosed coal workers' pneumoconiosis, coronary artery disease and obstructive lung disease. He said the Claimant could return as needed.

The Claimant also submitted notes of visits to a Black Lung Clinic on July 10, 2000 and March 8, 2004, where he was examined by Kellie Brooks, a registered nurse, family nurse practitioner and licensed nurse practitioner. CX 4. On each of these visits, Ms. Brooks took social, family and medical histories and performed a physical examination. The Claimant reported a hacky cough, sometimes productive, progressively getting worse, and wheezing. The Claimant reported becoming short of breath walking or climbing stairs. Ms. Brook initially assessed the Claimant with dyspnea and respiratory abnormalities and later assessed coal workers' pneumoconiosis and COPD.

Medical Opinions Given in Connection with the Black Lung Claim

Dr. Forehand examined the Claimant on April 23, 1997 on behalf of the Department of Labor. DX 15. He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, blood gas studies and pulmonary function testing. He reported that the Claimant worked in the mines for 41 years. He reported a smoking history of a half to one pack per day for 30 years. The chest examination revealed diminished breath sounds

[4] It appears that the Claimant was referred to Dr. Smiddy by his representative in connection with the claim. However, as Dr. Smiddy continued to see the Claimant in follow-up after the referral, I have included Dr. Smiddy's report of his examination of the Claimant among the treatment records.

and wheezes in the right lower lobe. Dr. Forehand read the x-ray as showing pneumoconiosis. The pulmonary function test showed a mild obstructive ventilatory pattern. The arterial blood gas study was normal. Dr. Forehand diagnosed coal workers' pneumoconiosis based on history, pulmonary function studies, arterial blood gas studies and chest x-ray; and atherosclerotic cardiovascular disease. Dr. Forehand found that the Claimant had a mild impairment in function based on his lungs, and that he retained the respiratory capacity to perform his last job in the mines. Dr. Forehand stated that the Claimant would be unable to return to work because of his cardiac status.

On August 13, 2002, Dr. Smiddy wrote to the Claimant's representative. In his letter, he stated:

> This letter is to certify that this patient has coal workers pneumoconiosis to a significant degree. … Spirometry today reveals … a significant obstructive ventilatory defect even while taking bronchodilator medication.
>
> Considering this patient's performance status the patient is 100% totally and permanently disabled by his coal workers pneumoconiosis and certainly would not be able to do the type of employment required for coal mine related work.
>
> The patient is required to be constantly on bronchodilator medication …
>
> The patient's pulmonary function impairment is of a sufficient degree to interfere with his activities of daily living.

DX 59.

On March 31, 2004, Dr. Craven wrote a letter in support of the Claimant's application for benefits. CX 2. Dr. Craven is board certified in family medicine. CX 2 at 2. In his letter, Dr. Craven stated:

> I am writing a letter concerning [the Claimant's] pulmonary disease. [The Claimant] certainly has respiratory impairment. He has a history of coal exposure of which I am sure you have the details. The patient has evidence of impairment based on his difficulty with activities of daily living. With walking, he gets significantly short of breath when walking less than 150 feet. He has some sensation of shortness of breath when at rest.
>
> His pulse oximetry has been normal. His pulmonary function testing, however, is significantly affected. On August in 2002, force vital capacity was decreased to 72 percent. FEV1/FVC ratio was decreased to 65%. Patient requires persistent bronchodilator therapy to even obtain these levels.
>
> I have been seeing this patient … since approximately January of 2003. During this time, I have seen no significant improvement in his respiratory impairment.

CX 2 at 1.

Dr. Hippensteel examined the Claimant on behalf of the Employer on September 17, 1997, DX 38, and August 4, 2002, EX 5. Dr. Hippensteel is board-certified in internal medicine and pulmonary disease, and a B reader. He took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, blood gas studies and pulmonary function testing. Additionally, Dr. Hippensteel reviewed the Claimant's medical data. After the 1997 examination, Dr. Hippensteel found no pneumoconiosis or any coal dust related disease. He said the Claimant's breathing problems appeared to be related to his heart problems, because testing revealed normal pulmonary function. After the most recent examination, he reported that the Claimant worked in the mines for 39 years. He reported a smoking history of one pack per day for 38 years. The chest examination revealed sparse rhonchi bilaterally. Dr. Hippensteel read the x-ray as showing pneumoconiosis (2/1). The Claimant was unable to complete all of the pulmonary function tests, but there was no evidence of obstruction in the pre-bronchodilator study. His MVV was invalid and underestimated his true level of function. There was no restrictive disease. His diffusion was mildly reduced, but normal for the volume he inhaled. The arterial blood gas study was normal. The Claimant's carboxyhemoglobin level was significantly elevated, suggesting recent smoking. Dr. Hippensteel diagnosed simple coal workers' pneumoconiosis. Dr. Hippensteel found that the Claimant had no impairment in function based on his lungs, and that he retained the respiratory capacity to perform his last job in the mines. Specifically, Dr. Hippensteel stated that the Claimant would be unable to return to work because of his age and orthopedic problems. In a deposition taken on October 25, 2004, Dr. Hippensteel testified regarding his examination of the Claimant. EX 11. Dr. Hippensteel reiterated the opinion he gave at the time of the examination.

Dr. Dahhan reviewed the Claimant's medical records and provided reports dated September 21, 1998, DX 44, DX 45, and September 28, 2004, EX 9. Dr. Dahhan is a board-certified pulmonologist, and a B reader. In the earlier report, he thought there was insufficient evidence to justify a diagnosis of coal workers' pneumoconiosis, and no objective findings to indicate any pulmonary impairment. However, in the most recent report, he diagnosed simple pneumoconiosis based on the radiological findings. He said there was no evidence of complicated pneumoconiosis or progressive fibrosis. He reported a mild obstructive respiratory impairment with normal blood gas exchange. He said the Claimant retained the pulmonary capacity to perform his previous coal mine work, but had multiple other medical problems not related to coal mine dust exposure.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition

> includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2006).

Twenty CFR § 718.202(a) (2006) provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in Sections 718.304 (irrebuttable presumption of total disability due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982) or 718.306 (applicable only to deceased miners), or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that the Claimant has had a lung biopsy, and, of course, no autopsy has been performed. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, the Claimant filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. Absent contrary evidence, evidence relevant to either category may establish the existence of pneumoconiosis. In the face of conflicting evidence, however, I must weigh all of the evidence together in reaching my finding whether the Claimant has established that he has pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. See *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp.*, 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co.*, 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v.*

Director, OWCP, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

Although there is conflicting evidence, three of the five x-rays taken since 2000 are positive for pneumoconiosis, and all of the doctors who gave opinions in connection with the current claim, even those retained by the Employer, concur that the Claimant has pneumoconiosis. I find that the Claimant has established that he has coal workers' pneumoconiosis.

Causal Relationship Between Pneumoconiosis and Coal Mine Employment

The Act and the regulations provide for a rebuttable presumption that pneumoconiosis arose out of coal mine employment if a miner with pneumoconiosis was employed in the mines for ten or more years. 30 U.S.C. § 921(c)(1); 20 CFR § 718.203(b) (2006). The Claimant was employed as a miner for at least 39 years, and therefore is entitled to the presumption. The Employer has not offered evidence sufficient to rebut the presumption. I find that the Claimant has established a causal relationship between his pneumoconiosis and his coal mine employment.

Total Pulmonary or Respiratory Disability

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 CFR § 718.304 (2006), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 CFR § 718.204(b) and (c) (2006). The regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and (5) lay testimony. 20 CFR § 718.204(b) and (d) (2006). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 CFR § 718.204(d) (2006); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). There is no evidence in the record that the Claimant suffers from complicated pneumoconiosis or cor pulmonale. Thus I will consider pulmonary function studies, blood gas studies and medical opinions. In the absence of contrary probative evidence, evidence from any of these categories may establish disability. If there is contrary evidence, however, I must weigh all the evidence in reaching a determination whether disability has been established. 20 CFR § 718.204(b)(2) (2006); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986).

In connection with the current claim, the results of eight pulmonary function studies were admitted into the record. Of those, only two produced qualifying results, and one of those was determined to be invalid. Moreover, the three most recent tests produced non-qualifying results. As a result, I cannot find total disability based upon the pulmonary function studies.

None of the arterial blood gas studies are qualifying. Therefore, I cannot find total disability based upon the arterial blood gas studies.

Next, I must review the medical opinions. Drs. Forehand, Smiddy, Hippensteel, and Dahhan each provided an explicit medical opinion on the issue of total disability. Dr. Smiddy stated that the Claimant is disabled. Dr. Craven implied, but did not state outright, that the Claimant is disabled. However, both Dr. Smiddy and Dr. Craven relied on invalid or non-qualifying pulmonary function tests in reaching their opinions. On the other hand, Drs. Forehand, Hippensteel and Dahhan were of the opinion that the Claimant is not disabled. Drs. Forehand and Hippensteel examined the Claimant, and Drs. Hippensteel and Dahhan had numerous medical records covering an extended time period available for their review. Drs. Hippensteel and Dahhan have the best relevant qualifications, as they are both board certified in internal medicine and pulmonary disease. They also had access to more complete information, and their opinions were more consistent with the objective evidence. I find that the well-documented and well-reasoned opinions of Drs Hippensteel and Dahhan, supported by Dr. Forehand's opinion, that the Claimant is not disabled, are entitled to greater weight than the less well-documented and less well-reasoned opinions of Drs. Smiddy and Craven. I give no weight to the opinion of the nurse practitioner. The weight of the medical opinion evidence does not support the conclusion that the Claimant is totally disabled by a pulmonary or respiratory impairment.

I conclude that the Claimant has failed to establish that he totally disabled by a pulmonary or respiratory impairment. Thus I find that the Claimant has failed to establish a mistake of fact in Judge Roketenetz' decision that he is not disabled. Nor do I find that there has been a material change in conditions since Judge Roketenetz denied the claim.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Because the Claimant has failed to meet his burden to establish that there has been a change in conditions or a mistake in determination of fact in the decision on his duplicate claim, or that there has been a material change in conditions since the denial of his previous claim became final, he is not entitled to benefits under the Act.

ORDER

The request for modification filed by the Claimant on October 3, 2003, is hereby DENIED.

A

ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of

Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).